TRADITIONAL ACCESS (FFS) PLAN

BENEFIT	COST SHARING
Deductible Maximum out of Pocket for Covered Expenses After Deductible Coinsurance Lifetime Maximum Benefit	Single $400 Family $800 Single $1500 Family $3000 As Indicated Unlimited
In-Hospital Care - Authorized Semi Private Room and Misc. Services, Intensive/Cardiac/Neonatal	15% Coinsurance Amount*
Ambulatory/Hospital Outpatient Surgery	20% Coinsurance Amount*
Transplant (Kidney, Cornea, Bone Marrow, Heart, Liver, Lung, Heart/Lung, Pancreas, Small Bowel)	15% Coinsurance Amount*
Out-Patient Services - Provider Office Visit, Diagnostic & Allergy Testing, Allergy Serum and Injections, Diabetes Education and Therapy, Radiation, Chemotherapy, and Dialysis	20% Coinsurance Amount*
Maternity Care - Prenatal, Labor, Delivery and Postpartum (Pregnancy of Dependents Covered)	15% Coinsurance Amount*
Emergency Services - Hospital Emergency Room (Coinsurance Waived if Admitted), Ground Only Ambulance	20% Coinsurance Amount*
Preventive Services: Immunizations Well Child Care - Age and Periodicity Limits May Apply Well Adult Care - Age and Periodicity Limits May Apply	 10% Coinsurance Amount Per Plan Year Ages 0-3 Office Visits Covered to $200 - Ages 4-18 Office Visits Covered to $100 - No Coverage Above Limit No Coinsurance Amount/No Deductible Per Plan Year $300 for Routine Physical Exam and Specified Testing - No Coverage Above Limit No Coinsurance Amount/No Deductible
Mental Health: Inpatient Outpatient	 20% Coinsurance Amount, 21 days/plan year, 1 admission/6 months (Day Treatment/Intensive Outpatient Can be Substituted for Inpatient Days on a 2 for 1 Basis)* 20% Coinsurance Amount*, 20 visits per plan year
Autism - $500 Monthly Benefit for Children Ages 2 through 21 years of Age for Therapeutic, Respite and Rehabilitative Care	Coinsurance Applicable to Service Provided*
Substance Abuse: Inpatient Outpatient	 20% Coinsurance Amount, 21 days/plan year, 1 admission/6 months (Day Treatment/Intensive Outpatient Can be Substituted for Inpatient Days on a 2 for 1 Basis)* 20% Coinsurance Amount*, 20 visits per plan year
Prescription Drugs, including Oral Contraceptives	20% Coinsurance Amount* - 1 month supply unless mail order available
Physical/Occupational/Cardiac Rehabilitation Therapy	20% Coinsurance Amount* 26 Weeks/Plan Year
Speech Therapy	20% Coinsurance Amount* 26 Weeks/Plan Year
Home Health Care	100 \ Visits Per Plan Year Covered in Full*
Skilled Nursing Facility	20% Coinsurance Amount* 28 Days/Plan Year
DME/Prosthetics/Hearing Aids	20% Coinsurance Amount*
Hospice	Medicare Benefit*

*Deductible Applies. The single and family deductible amounts may be either:

- A combined deductible for both medical and pharmacy services; or
- A split deductible with a set amount for medical services and for pharmacy services.